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received
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Fax Transmittal

Date: 7-17

To: Cynthia Balcar

Phone:

Fax: 907-283-3814

From:

Pages: *(including this page)*

Subject:
Walker

Comments:
Life Care Plan.

DATE: March 26, 2003

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Re: Mr. Joel D. Wallender
DOB: 7/9/1968

File #: 668-044616
Date of Injury: August 5, 2002

To: Nancie Lamson
From: Shelli Smith RN, CLCP

Mr. Joel D. Wallender is a 34 year old man who was injured in a construction accident when he fell three stories to the ground, landing on a pile of 2 by 4's. He was initially transported via ambulance to Fairbanks Memorial Hospital.

Upon arrival Dr. Sean Wormuth evaluated Mr. Wallender. Due to altered mental status he was intubated and spinal cord injury protocol was initiated. Laboratory evaluation revealed his toxicology screen was positive for tricyclics and marijuana. Blood, protein and glucose were present in the urine. Although Mr. Wallender was confused, he was able to spontaneously move his upper extremities, but showed no movement, specifically no hip flexion in his lower extremities.

Chest x-rays revealed small bilateral hemopneumothoraces. Head CT revealed a frontal lobe contusion with associated small subdural hematoma. X-rays of the lumbar spine revealed fractures at the level of T8, T11, T12, and L3. Rib fractures were also noted at the 10th, 11th and 12th ribs.

Dr. Wormuth reported, "Given the patient's need for stabilization of his back and further neurosurgical care for his head injury, it was decided to transfer the patient to Anchorage.

Bilateral chest tubes were placed and he was transported via air ambulance to Providence Alaska Medical Center in Anchorage, Alaska.

According to the 9/10/02 discharge summary of neurosurgeon Dr. John Godersky:

"He suffered a head injury with bifrontal contusion, had bilateral chest tubes placed for hemopneumothoraces, [he] was noted to be paraplegic with thoracic fractures involving T10, T11, T8 and L3. He was intubated prior to transport from Fairbanks to Providence Alaska Medical Center. Following admission to the hospital, he was cared for by Dr. Peters from general surgery. Neurosurgical consultation was obtained regarding management of his spinal cord injury and spinal fracture.

He developed respiratory failure soon after admission with bilateral pulmonary infiltrates. He was

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treated with various antibiotic regimes but it took about two weeks for his pulmonary status to clear to the point that he could be extubated. Surgery for posterior spinal reconstruction was delayed until his respiratory status improved. He was then taken to the operating room on 8/26/02 for posterior spinal reconstruction from T7 to L3.

He tolerated this procedure fairly well. His respiratory status did not worsen following this operation. He had been transfused preoperatively and was again transfused postoperatively. He remained paraplegic with approximately a T12 motor and sensory level. As his general status improved, he was moved from the intensive care unit to the general neurosurgical ward. He was fitted with a bivalved TLSO. He was mobilized in his brace. A consultation was obtained from rehabilitation medicine. Physical therapy and occupational therapy were initiated.

He had a laceration on the back of his scalp at the time of his initial injury. This was repaired in the emergency room but became infected and the staples were removed. At the time of his posterior spinal reconstruction, this wound was debrided and reclosed. It is, at this time, healing well.

He is on a general diet. He is able to be mobilized to a wheelchair although he still has some orthostatic hypotensive symptoms. His Foley catheter remains in place. His head injury for the most part has resolved.

At his family's request he is being transferred to Craig Hospital in Denver, Colorado for further management of his head injury and spinal cord injury. The following p.r.n. medications will be provided to him at the time of transfer. These include Lovenox 30 mg subcutaneously every 12 hours. Albuterol inhaler four puffs every four hours, Flexeril 10 mg p.o. every eight hours, OxyContin 30 mg p.o. every 12 hours and Oxy-IR 15 mg p.o. every six hours as needed for breakthrough pain."

Discharge diagnoses were:
1. Multiple thoracic fractures with paraplegia.
2. L3 fracture, stable.
3. Head injury with bifrontal hemorrhagic contusions.
4. Respiratory failure with bilateral pulmonary infiltrates and pneumonia.
5. Bilateral hemopneumothoraces, resolved.
6. Left scapular fracture.
7. Rib fractures, left T10, T11, and T12.
8. Scalp laceration, repaired times two.

Procedures performed were:
1. CT scans of the head, neck, chest, abdomen, and pelvis.
2. CT scan of the thoracic spine.
3. Endotrachial intubation with mechanical ventilation.
4. Posterior spinal reconstruction, T7 to L3, with hood and rod construction and iliac crest graft.
5. Debridement and repair of scalp laceration.

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9/10/02 - Mr. Wallender was transferred via air to Craig Hospital in Denver, Colorado for continued care and comprehensive brain injury and spinal cord injury rehabilitation.

Upon arrival he was evaluated by Dr. Alan Weintraub. He reported, "He sustained multiple traumas, including bifrontal left greater than right intracerebral contusion and traumatic spinal fractures of T8, T10, T11, T12, and L2 with a T12 complete spinal cord injury, ASIA Impairment A.... The specifics in his injury relate to acute bifrontal contusion noted on CT scan of the brain and a Glasgow Coma Score of 8.... He never had seizures. He is no longer on seizure prophylaxis. He never required intracerebral monitoring or post traumatic edema management measures." Problems with incontinence, short term memory, attention, concentration, thought organization and executive functioning were noted.

Mr. Wallender was discharged from Craig Hospital on 12/12/02.

Dr. Weintraub reported:

"The patient was admitted to the brain injury program. He had intensive management of his neuro-medical issues, spinal cord injury, brain injury, and comprehensive rehabilitation. He was followed by consultants, as well as PT, OT, speech, neuropsychology, rec therapy and family services. The following issues were managed:

1. Traumatic spinal cord injury: He had thoracic 12 paraplegia Asia Impairment A. We checked films, and an MRI scan of the thoracic spine showed non-cystic myelopathy with myelomalacia at T11-12 without any ascending or descending changes...He was having a significant amount of pain at this fracture site for the first three to four weeks of his admission. It was felt that this had a mechanical component. He continued to wear his TLSO and eventually, progressed to a Jewett brace. He was followed by Panorama Orthopedics, and his spine fractures did appear stable. Ultimately, his back pain got better, pain medications were tapered, including his Duragesic patch, and his spinal cord injury level T12 paraplegia Asia Impairment did not change. It was not felt that he required any further spinal surgery throughout his hospital course.

2. Encephalopathy; he came out of post traumatic amnesia about three weeks after injury. Sertal imaging studies showed bifrontal subdural hygromas. These eventually resolved. He did have a bilateral inferior frontotemporal brain injury and at the time of admission, was a Level V emerging VI and at the time of discharge is Level VII-VIII. His perseveration initially post injury got better and his mood significantly improved, as did his sleep cycles. At the time of discharge, he had shown cognitive improvements in a dramatic fashion. He showed attention span within normal limits on sustained selective divided alternating attention, and he significantly improved in his ability to filter out background noise. His performance on memory recall improved after delays and he was showing more retention of procedures and his ability to learn education information related to his spinal cord injury. His speed of processing was functional.

3. Respiratory status: He never had any significant difficulties in this regard. He was able to take p.o. well. He never had any atelectasis or evidence for tracheal bronchitis. He was on respiratory care treatment throughout his hospital course.

4. GI status: At the time of admission, he had resolving pancreatitis. He had elevation of his

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amylase and lipase, and he also had a mild degree of gastropareisis. He required gastrokinetic agents, Reglan, and was ultimately switched to Zelnorm. This was very helpful for him. Combined with H2 antagonists for gastritis and time, he eventually improved. He had nausea, vomiting, diarrhea, and loose stools during the first months of his stay. In addition to his gastroparesis and resolving pancreatitis, he had C difficile colitis. All of these issues were treated and resolved prior to his discharge.

5. Hyponatremia: He had severe SIADH [syndrome of improper antidiuretic hormone]. He was followed by nephrology. He required hyertonic saline early in the course and ultimately was placed on Declomycin, which was eventually tapered, and he was on fluid restriction. His sodium improved to approximately 136 and, thereafter, never became a problem.

6. Neurogenic bladder: He did have a history of recurrent UTI, bacteriuria and pyuria. He was treated with antibiotics on several occasions. He had a urology evaluation and had irrigation and removal of grit and stones, and mucus and debris. He had some external sphincter dyssynergia and spasticity and he did progress to independence in his intermittent catheterization program.

7. Neurogenic bowel: The patient progressed to independence in his bowel program.

8. Rehabilitation issues: The patient was planned for discharge on 12/12/02. He is returning to Alaska to live with family and accessible housing has been designed, as well as all equipment being procured. He is doing his ADL activities and wheelchair skills at longer distances. He is able to follow through on dressing, hygiene, bed mobility, padding appropriately, and he has had his equipment procured.

9. Psychologically, the patient improved significantly on an antidepressant, Effexor XR 75 mg. He required low dose Norpramin 10 mg b.i.d. to help with sweating phenomena he was experiencing and he required low dose Neurontin at night for deafferent pain symptoms in his legs."

Final diagnoses were:

1. *Encephalopathy secondary to a fall with bifrontal hemorrhagic contusions, Glasgow score 8, posttraumatic amnesia three weeks with residual improved organic brain syndrome from Level V-VI at admission to Level VII emerging VIII at discharge.*
2. *Traumatic paraplegia, T12 last fully preserved motor/sensory level with distal light touch sensory sparing. Asia Impairment Scale B secondary to T8, 11, 12 and L2 fractures.*
3. *History of T7 through L3 posterior spinal reconstruction stabilization with iliac crest graft.*
4. *History of L3 fracture, deemed stable.*
5. *History of left scapular fracture and rib fractures, left 10, 11 and 12.*
6. *History of bilateral pneumothoracies requiring chest tubes.*
7. *History of pancreatitis.*
8. *History of gastroparesis.*
9. *History of hyponatremia, SIADH.*
10. *Neurogenic bladder, on intermittent catheterization program.*
11. *History of UTI and cystoscopy with removal of mucous and debris.*
12. *History of respiratory insufficiency, ventilatory support, pulmonary infiltrates, and pneumonia, resolved.*
13. *Neurogenic bowel.*

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Discharge medications were:

1. *Neurontin 300 mg at bedtime*
2. *Norpramin 10 mg twice daily for sweating*
3. *Hiprex 1 gram per day for urinary suppression*
4. *Effexor XR 75 mg per day*
5. *Colace 100 mg twice daily*
6. *CranActin one twice daily*
7. *Lortab, one to two every 6 hours as needed for pain*
8. *Tinactin spray two times per day between his toes*
9. *Magic Bullet suppository every other day*

In his discharge summary Dr. Weintraub recommended follow up at Craig Hospital in 6 months for reevaluation of his bowel and bladder management and his physical and cognitive functioning in the context of his "overall life skills."

In preparing this report the medical records forwarded from the claim file, Nurse case manager file, ExPRS journal entries, action plan and BOcomp managed pay screens were reviewed. In addition letters were faxed to Dr. Shawn Johnston and Dr. Greg Lund. Their responses are contained within the body of the life care plan.

Given an average life expectancy of 75 years {1} his future medical costs could be as follows. Inflationary factors have been applied to this report. Please do not hesitate to call me at 503-736-7468 if you have questions or concerns regarding the information presented in this report.